

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157646	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/06/2012
NAME OF PROVIDER OR SUPPLIER FREEDOM HOME HEALTH OF INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7215 EAST 21ST STREET, SUITE A INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 000	<p>INITIAL COMMENTS</p> <p>This visit was for an initial Medicaid certification survey.</p> <p>Facility: # 12818</p> <p>Survey Date: 06/04-06/12</p> <p>Medicaid #: N/A</p> <p>Surveyor: Marty Coons, RN, PHNS-Team Leader Linda Dubak, RN, PHNS</p> <p>Freedom Home Health of Indiana has met the Conditions of Participation at 42 CFR Part 484.</p> <p>Census-9 Home Visits-5 Clinical Records Reviewed-5</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 8, 2012</p>	G 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.